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Family Changes Resulting From a Life Threatening Illness: Cancer. A Case Study Approach.

by

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Date June 11, 1982

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In memory of my father

Abstract

The present study addressed the issue of family change as a result of a life threatening illness in the adult female member. The illness dealt with was nonterminal cancer. A case study approach was utilized to investigate three areas. The first was to determine what changes a family goes through in a variety of daily living domains following a cancer diagnosis and what has facilitated these changes. Second, what interaction and communication patterns were evident in family members with particular reference to symmetry and complementarity? Third, what rules could be inferred through observations and responses to questions and how do these rules relate to the changes? These objectives were accomplished via a semistructured interview technique used to collect data from two volunteer families.

Interview data were analyzed with respect to similarities and differences between the two families. As well, symmetrical and complementary interaction patterns were studied to determine if there was any relationship between these patterns and changes the family had gone through.

Analysis revealed that the two families enjoyed considerable success in adapting and accommodating to the challenge of a life threatening illness. Both faced some major changes; however, old patterns were quickly resumed

following the recuperation period. As well, a relationship between symmetrical and complementary interaction patterns, inferred family rules, and changes the family encountered was evident in determining adaptation during the crisis period.

The present research, being a descriptive case study and exploratory in nature, undoubtedly has its limitations. Although generalizations of findings are limited, the overall approach appeared applicable to the study of changes in a family resulting from cancer. Implications of the findings for family counselling interventions are presented, and suggestions for future research are offered.

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Introduction

Numerous studies have been done related to the daily activities and routines one experiences. When a crisis event occurs these routines are necessarily disrupted (Bermann, 1973), and changes evolve to allow adaptation to a new set of circumstances. Little is known, however, about this process of change. This lack of knowledge holds even truer in relation to a family. The family is a private institution, a closed social system. Little naturalistic observation has been done to penetrate the privacy of this system (Bermann, 1973).

The present study investigated family issues, changes and patterns of behaviour when a crisis occured in a member. The crisis referred to is the diagnosis of cancer in the female adult member. Although cancer had been chosen as the illness from which the crisis arose and is the illness present in the subject families, the main focus here was the change resulting from a crisis illness. The fact that it was cancer *per se* may be seen as secondary. The reason cancer was chosen is because of its negative connotations, and a diagnosis of 'cancer' almost always precipitates a time of stress and crisis.

The illness can interfere with daily activities, including earning capacity, social and familial relationships, plans, needs and sexual activities. Changes

occur in family activities, roles and interactions. Family members have to adapt to new routines and changes. A physical illness is a problem of the whole person; not only is the body affected, but also the mind and the emotions.

Cancer is not just another chronic disease. It evokes many of the deepest fears of mankind. Despite treatment, it can spread throughout the body. As well, it can affect emotional and social domains, disrupting families and lives. Often cancer is associated with losing control of one's body, enhancing a sense of isolation, alienation and fear, thereby resulting in anger and denial, disrupted lives, pain, stigmatization and rejection. However, there is also evidence of the families and friends finding strength in the struggle, overcoming the initial fear, anger, bitterness and depression and learning to live in the fullest capacity possible (Regush, 1981). As well, there are those cancers which are cured, leaving the patient and his/her family free to live with the joy of overcoming the illness. Cancer can be viewed as a test for marriage and a family. It is like a stranger invading an established way of life. Families that function well usually have the ability to take risks, attempt new alternatives and consider new ideas during crises. One family member, or the family as a whole may be innovative in accommodating to their new situation. Existing rule structures can be altered to allow the family to function as an efficient problem solving group and successfully emerge from the crisis.

The task of the present research was twofold. When a family member is diagnosed as having a chronic illness, there will inevitably be some changes which the family as a whole has to go through. Under normal conditions, a family functions within the same rules which can persist for years. When illness occurs, depending on the existing rules, the family may be forced to change some of these rules and accommodate and adapt itself to living under new conditions. Each family member plays a significant role in determining what and how changes occur in the context of a crisis and stress. In a sense the family's life may become organized around the illness. The author proposed to examine what some of these changes were, as well as what has facilitated them. What allowed family members to adjust to their new situation, and who has helped them in the process?

Secondly, interaction and communication patterns were investigated. The author examined how family members communicated and related to each other. Within this context, attempts were made to determine if these communication patterns were established after the cancer or were present before the cancer existed. In addition, there was a specific focus on whether the patterns were connected to changes the family has gone through. Were these patterns responsible for how the family dealt with the crisis situation?

There is much to be learned about a family under the circumstances of this type of life crisis. To better understand what occurs, one needs to speak directly with the

family on these issues. Through a descriptive case study approach, the author hoped to add knowledge to the area of family change and adaptation as a result of cancer.

In summary, the present research addressed the changes a family went through when a member, in this case the wife/mother, was diagnosed as having cancer. It investigated changes in daily household routines, roles held by family members and rules present in the household. The following research questions were explored: 1) What changes has the family gone through since the cancer diagnosis in a variety of areas in every day living? 2) What roles are evident in family members in terms of symmetry and complementarity? 3) On the basis of interview responses and observed patterns, what rules can be inferred about the family's interaction and communication patterns and how are these rules related to the adaptation process?

Literature Review

There is a vast amount of literature which can be related to the present study. The review will cover six main areas which the writer felt contributed to the present research. The first section will provide a brief overview of the physical aspects of cancer; what the illness is, what causes it, and how it is treated. This will be followed by a discussion of the psychological and psychosocial aspects related to cancer, including various stages the patient and his/her family go through, and possible effects of the illness. As the author is hypothesizing that a change as a result of illness in one family member will bring about change in other members as well, the third area will describe the family as a system. This section emphasizes how the family functions as an interrelated unit, each member's behaviour affecting the others. The fourth section covers communication and interaction patterns. Complementary and symmetrical interchanges will be focused upon. The fifth and sixth areas discussed, respectively, are coping with stress and crisis, and the transitions and changes often resulting from an illness.

Cancer-The Chronic Illness

Cancer is one of the most prevalent illnesses today. In 1979, there were 38,971 deaths per 23,670,600 population resulting from neoplasms (tumours) in Canada (Statistics Canada), compared to 37,498 per 23,482,600 in 1978. In 1979, the death rate was 164.6 per 100,000 population, indicating an increase from 138.7 in 1978. In Alberta, the death rate in 1978 was 124.2. The rate for new primary sites in Canada was 350.1 and 291.2 for Alberta.

Cancer is a disorder of cellular growth in which the cells are no longer subject to the restraining influences normally controlling their behaviour. The first stage in the development of cancer is an abnormal change in one of the cells of the body. A disorder of the cell's controlling mechanism leads to a disorder in cell growth. This faulty cell with unregulated, uncontrolled and purposeless growth can become a malignant tumour. Cancer cells can reproduce themselves and give rise to daughter cells which in turn reproduce further cancer cells. Eventually, after a few divisions, a clump of cancer cells is produced. This tissue mass appears as a lump or a swelling at the site where the first malignant change took place in a cell. If the lump is not treated, some of the cells will grow into the surrounding regions (Scott, 1979; Sutton, 1966). Cancer is found in all parts of the body and in all ages, some types

being more common in children and others in adults.

What the actual cause of cancer is remains a mystery. However there have been many hypotheses suggested. Possibilities include that cancer is due to infection by viruses, it may be caused by chemical substances, atomic radiation or a somatic mutation which is a genetic abnormality. Specialists believe that more than 80% of the causes of cancer are environmental and not genetic. A more recent theory is that a gene capable of causing cancerous growth is normally present in human cells but it remains inactive. For unknown reasons it can become active and lead to unrestrained cell growth we know as cancer (Scott, 1979).

Another theory put forth, with research findings cited to support it, (LeShan, 1977) is that cancer victims have a psychological orientation which increases the chances of their getting cancer. According to this point of view, the individual's childhood or adolescence would have been marked by feelings of isolation and neglect. There is then a period in which a meaningful relationship is discovered. The loss of this central relationship and a sense of despair occurs. After this phase, the first symptoms of cancer are noted. LeShan hypothesizes that the loss of a meaningful relationship strongly contributes to the development of cancer. It related directly to personality and to the way the patient saw himself in the world. As well, cancer patients are less able to express their feelings than noncancer individuals. Often, the tendency is for the

individual to not feel good about himself. For example, he is constantly working to please others, especially his parents.

There are three ways in which a cancer can spread through the body. The first, is by direct extension into surrounding tissue area. The second, is when cells break off from the original tumour and travel through the blood stream and to other body regions. The third way, is by the lymphatic vessels to the lymphatic glands.

There are various types of cancer. It is not one disease, but more than 100. It is a variety of related diseases affecting different parts of the body. Cancer of the breast is the most common type in women and lung cancer is the most common type in men. Other common types are cancer of the stomach, bowel and rectum, pancreas, cervix, ovary, prostate, bladder, intestine, skin, larynx and brain. Aside from cancers of various organs, there are those in lymphatic glands, the most common being Hodgkin's disease, and leukaemia, which is cancer of the blood.

Three types of procedures are most common in cancer treatment. The first is surgery. The surgeon aims to remove the entire tumour, or as much of it as possible, leaving no cancer cells behind. For this to be successful, the tumour must be confined to one area. A second treatment is radiotherapy, exposing the tumour to ionizing rays such as those emitted by an x-ray tube. Radiation is capable of killing cells, especially when they are in the process of

dividing. Chemotherapy, the third common method is treatment by chemical agents or drugs. Often, a combination of one or more treatments can be used (Scott, 1979; Sutton, 1966).

Psychological and Psychosocial Aspects of Cancer

Although cancer is a physical desease, it not only affects the body, but it has direct consequences on one's emotions, thoughts and social relationships.

"The doctor has said it. Cancer. The patient's mind screams it. Cancer. Does anyone hear the screams? Anyone at all? Please, someone, listen..." (Keeling, 1976, p.502).

Almost always this is the initial reaction to a diagnosis of cancer. Many people are immobilized by the word. Fear, controlled terror, and emotional tensions come to mind. Psychological adjustment to cancer is a process which begins with the suspicion or diagnosis of the disease, moves into the hospitalization treatment or surgical period, and finally, into a rehabilitation period or terminal prognosis (McCollum, 1978).

Kubler-Ross (1969) is known for her work on death and dying. She claims that there are five stages one tends to go through when faced with an illness and potential death. The first reaction is denial; "No, not me, it cannot be true." This denial functions as a buffer after unexpected shocking news. This is a temporary defense soon replaced by partial

acceptance. Depending on how a patient is told and how he is prepared to cope with life stresses, he will gradually drop his denial and use less radical defense mechanisms. The second phase is anger, rage and resentment. This is often projected onto the environment, with the patient finding grievances in everything. Phase three is a bargaining phase. This is an attempt to postpone the inevitable from happening. One may promise something for the future if only he would get well now. Depression is the fourth phase. A sense of great loss replaces earlier feelings. Finally, acceptance will occur. If a patient has had enough time, has had some help in working through the previous stages and has expressed his feelings, a stage of acceptance will be reached. One thing that persists through all five stages is hope, hope for a cure or a new miracle drug. Although these are the five prominent stages, not everyone goes through them all. Some might skip a stage, some may stay in one for a very long time, others may even go through one more than once.

Family members undergo different stages of adjustment similar to those of a patient (Kubler-Ross, 1969). At first they cannot believe it is true and deny that there is such an illness in the family. They may shop around from one doctor to another hoping to hear that it was a wrong diagnosis. Only gradually will they face up to the reality which may change their lives so drastically. If they are able to share their common concerns with the patient, then

they can take care of important matters. If each one keeps the issue a secret, they will keep an artificial barrier between them which will make it difficult for preparatory grief for both the patient and his family. The end result will be more dramatic than for those who can talk and cry together at times. The family then goes through the same stage of anger, at the doctor or hospital personnel. They will feel guilty for missed opportunities. If the patient is terminally ill, the family will go through a phase of preparatory grief. If members of a family can share their emotions together, they will gradually face the reality of the situation and come to an acceptance of it together. If a family can talk, cry, scream, ventilate and share, and be available for each other, it will help them direct their needs constructively to diminish negative feelings such as guilt, shame and fear. The entire family needs support just as the patient does.

Weisman (1972) suggests that one goes through three psychosocial stages. The first stage, even before the cancer is diagnosed, is denial and postponement. People will often delay and postpone going to a doctor to check out possible signs and symptoms. Stage two is mitigation and displacement. Adjustments can extend over a period of months or even years. This stage has three substages. The initial response is to be nostalgic about the past, recalling missed opportunities and remorse, or, on the other hand, initial responses may revive memories of better days. Intermediate

response is a period of uncertainty, and lastly, preterminal responses include last shreds of hope. One may seek the advice of another doctor, or may seek a miracle cure. The last stage is counter control and cessation. This is the period of decline, diminished autonomy and relapses.

Cancer has a variety of effects on an individual and his family. Often there is withdrawal from the social world. There are problems relating to others. You feel different about yourself and others begin treating you strangely (Keeling, 1976). As a result of disrupted communication, alienation and isolation are common. Often people are ignorant of how to act when in the presence of a cancer patient and his family. They are afraid to say the wrong thing or act the wrong way. They do not know what is expected of them. A study on cancer survival rates shows longevity to be significantly correlated with patients who manage to maintain active and mutually responsive relationships, while shorter survival was found among patients who reflected alienation, deprivation, depression and destructive relationships. Those with longer survival had good relationships with others, maintained intimacy with family and friends, and asked for and received medical and emotional support. Those with poor social relationships and pessimistic attitudes had shorter survival. (Weisman, 1975).

Physical and psychological problems are combined in what Rothenberg (1961) claims are five prominent interpersonal issues operating in cancer. The loss of

control and mastery of one's own body is one of the most difficult aspects to accept. The patient is unable to control the cancer process. Secondly, denial of the existence of the disease is a way to tolerate the cancer experience. Then, grief results from the prospect of loss of body function, or death. A sense of failure occurs as the body begins to fail and the patient is generally in a physically incompetent state. Lastly is the feeling of isolation which includes withholding information about the cancer, disrupted communication and withdrawal of others. It is clear how a patient dealing with these issues changes within himself and subsequently causes changes to occur in the rest of his family.

Simonton, Simonton and Creighton (1978) believe that we each participate in our own health or illness through beliefs, feelings, attitudes toward life and more directly through exercise and diet. We can use our own resources and actively participate in our recovery. Patients who do well in treatment have a will to live; "I can't die, my family still needs me." They have the belief that they can somehow influence the disease. They have a positive attitude and positive expectations about overcoming the cancer. Patients use mental imagery and imagine their system combating the cancer. The authors believe that high levels of emotional stress increase susceptibility to illness. A chronic stress results in a suppression of the immune system, which in turn creates increased susceptibility to illness. Emotional

stress which suppresses the immune system also leads to hormonal imbalances which could increase the production of abnormal cells at a time when the body is least capable of destroying them.

Research suggests that there are five steps of a psychological process that frequently precede the onset of cancer (LeShan, 1977; Simonton, Simonton & Creighton, 1978). They are: 1)Experiences in childhood result in decisions to be a certain kind of person. Children may set rules for themselves as a result of a painful or traumatic experience, which prove to be a terrible strain when they are adults. 2) The individual is rocked by a cluster of stressful life events. The stresses often threaten personal identity, for example, the death of a loved one, or the loss of a significant role. 3) These stresses create a problem with which the individual does not know how to deal. The individual is unable to cope with the new situation. 4) The individual sees no way of changing the rules about how he or she must act and so feels trapped and helpless to resolve the problem. He sees himself as the victim, incapable of altering his life. 5) The individual puts distance between himself or herself and the problem, becoming static, unchanging, rigid. He just gives up on life, life has no meaning and serious illness may be seen as a solution. This giving up on life plays a role in interfering with the immune system, and through changes in hormonal balance, may lead to an increase in the production of abnormal cells.

This is just the right climate for cancer to develop.

Simonton, Simonton and Creighton (1978) follow up with four psychological steps that facilitate recovery. 1) With the diagnosis of a life threatening illness, the individual gains a new perspective on his or her problems. The threat of death allows one to express anger and hostility; assertive behaviour is now permissable. 2) The individual makes a decision to alter behaviour, to be a different kind of person. Illness brings suspended rules and new options. As behaviours change, conflicts may appear resolvable. There is increased freedom to act and use new resources. Depression often lifts as repressed feelings are released. 3) Physical processes in the body respond to the feelings of hope and renewed desire to live, creating a reinforcing cycle with the new mental state. Changes in the psychological state result in changes in the physical state. There is a cycle of improved physical state bringing new hope and desire to live which brings additional physical improvement. 4) The recovered patient is 'weller than well'. Patients who have recovered have strength, a positive self concept, a sense of control over their lives, and an improved level of psychological development

A cancer patient is often asked to modify life style to accommodate the disease. This accommodation can refer to having to stop working, partaking in less strenuous activities and generally slowing down one's life pace. Family members need support and guidance in coping as

patients do. They feel confused and inadequate as they watch a loved one go through a life threatening disease. This experience can cause frustration and rage, or enrichment with feelings of a rare love and intimacy.

Family Systems

Systems theory has recently gained increased recognition. The approach stresses how one variable, a, within any one system affects a second variable, b, which affects a third, c, and so on until n, with each one affecting the others. The parts are so related that a change in one will cause a change in all of them, as well as in the total system. A system is made up of different parts which are interconnected and interdependent with mutual causality each affecting the other (Watzlawick, Weakland & Fisch, 1974). In our own lives, the family system stands out as most prevalent.

The family may be viewed as a feedback loop. Cause and effect relationships are circular, not linear. Each person's behaviour is affected by, related to, and dependent on the other person's behaviour. This interpersonal system can be further subdivided into subsystems including mother-father, father-son and sister-brother. Every member of the family system is so related to its fellow members that if one member changes, all members will change. As well, the total

system will change. It will change to accommodate the new behaviour or it will mobilize its efforts to minimize the effect of the change. The system behaves as an inseparable whole. It is inadequate to view one person's behaviour in isolation. All behaviour influences and is influenced by others.

Systems is an interaction oriented approach. Individual personality and character is shaped by the individual's relations with others and is in response to typical interactions which occur in a particular interpersonal context (Watzlawick & Weakland, 1979). A family's life together is an endless cyclical process of movement from understanding and attachment to conflict and withdrawal. Together, family members move from good times to more difficult times and back again. It is unity of interacting personalities whose resources are pooled to develop reciprocal help giving relationships.

A family is a rule governed system. Its members behave in an organized repetitive manner. When illness occurs in one of the members it inevitably cuts into some of the already established rules and breaks up the repetitive behaviour. If an organized nature of family interaction were not present, not only daily chores, but the very survival of the unit would be in question. Therefore, when cancer or other threatening illnesses occur, the unit may have to reorganize, but ultimately, it will adhere to a new set of rules and repetitious sequences evident in all areas of its

daily functioning.

A family system reduces the effect of change by means of homeostatic devices. It tends to maintain equilibrium which helps it remain integrated and continuous. This homeostatic device may make changes difficult. Some families may be resistant to change. Others may be more willing to accommodate to a new situation. The system perspective allows us to look at persistence and helps us understand why families have difficulty changing (Montgomery, 1981).

When some event, whether it is internal or external, requires one member of the family system to behave in a new and different way, each and every other member will behave differently as well (Watzlawick, Weakland & Fisch, 1974). Serious illness may precipitate a crisis within a family, moving the system from an organized state into disequilibrium. Roles and rules must change to meet the crisis. The family needs to reorganize itself to gain a new equilibrium (Olsen, 1970). The diagnosis of cancer in one member will cause changes in a variety of areas of life. The rest of the family, too, will have to change to accommodate the ill member, a new way of life altered by new circumstances (Calhoun, Selby & King, 1976).

Interactional Communication Patterns

When investigating an area involving families, the inclusion of literature related to interaction and communication patterns is relevant as there is constant ongoing interpersonal relating. The setting and the process evident in a conversation can provide as much information as is available in the content itself.

Phenomena must be explained within the context in which they occur. It is not sufficient to look at the behaviour alone, or the context alone, but we should look at the relationship between the two. This can be observed in communication. The more 'healthy' a relationship, the more the communication aspect is less focused upon and recedes into the background. The interaction is not so distinct as the relationship is running smoothly. An unhealthy relationship is characterized by a constant struggle about its nature with content becoming less important. It is the process which requires attention.

Watzlawick, Beavin and Jackson (1967), make a distinction between digital and analogic communication. Digital communication reflects content in communication. It is the words individuals speak and gives information about facts, opinions and experiences. Analogic communication is all nonverbal communication including body movement, posture, gestures, facial expression and voice inflections.

It reflects the relationship aspect and defines the nature of the relationship between the communicants. The two modes complement each other in every message.

Relationships are defined as being complementary or symmetrical (Watzlawick, Beavin & Jackson, 1967). Complementarity and symmetry are two basic categories into which all communicational interchanges can be divided. Complementary interaction is when one partner's behaviour complements the other. The relationship tends to be based on the acceptance and enjoyment of difference. An example of this is when one member is assertive and the second is submissive. Symmetrical interaction is when partners tend to mirror each other's behaviour. The relationship is based on maintaining equality and the minimization of difference, for example, when one boasts, the other boasts, or, both agree with each other. Family patterns can be both, different members involved in different communication patterns. In a healthy relationship, both are present. Partners relate symmetrically in some areas, and complementarily in others.

If there is pathology in a symmetrical relationship, there is a danger of competitiveness. It follows that competitiveness may lead to pathology. This often results in quarrels and fights between individuals. In a healthy relationship, the partners accept each other leading to mutual respect, trust in the other's respect, and reciprocal confirmation of their selves. Breakdown of a healthy relationship leads to rejection.

Pathology in a complementary relationship leads to disconfirmation. As well, disconfirmation may lead to pathology. This occurs when one person, P, demands that another person, O, confirm a definition of P's self which varies from the way O sees self. Therefore, O must change his own definition of self which complements and therefore, supports P, since, by definition, P and O must maintain complementary roles. This leads to a sense of frustration and despair in one or both partners, frightening feelings and compulsive acting out. A healthy complementary relationship leads to positive confirmation of each other.

The terms rejection, confirmation and disconfirmation warrant further elaboration. Watzlawick and Weakland (1979) suggest there are three levels of interpersonal perception or, how you see others and how others see you. Rejection is when one person rejects what another is saying; 'you are wrong'. This presupposes at least limited recognition of what is being rejected. It may be constructive. Confirmation is acceptance of what the other is saying. This is the greatest single factor ensuring mental health and development, and stability. It builds a positive self concept, self esteem and confidence in oneself. The third level is disconfirmation, a disqualification or invalidation of what the other person is saying. It negates the reality of what is said. This is most often found in pathological families.

Watzlawick and Weakland (1979) speak of rules in a family. In every communication, participants offer each other definitions of their relationship. Each seeks to determine the nature of the relationship and responds with his definition of the relationship, confirming, rejecting or modifying that of the other. The stabilization of the relationship definition is the rule of the relationship. Families are rule governed systems. Members behave in an organized repetitive manner. This leads to set patterns of behaviour governing family life. These rules, whether overt or covert maintain homeostasis within the family system.

Coping With Stress and Crisis

In the present context, the actual diagnosis of the cancer illness is the factor creating the stress and subsequent crisis needing to be dealt with. A crisis is a period of disequilibrium which overpowers homeostatic mechanisms. Problems in a crisis are novel in previous life experiences and therefore cannot be handled by commonly used problem solving mechanisms. It forces the employment of new patterns (Hill, 1965; Montgomery, 1981). A family crisis occurs when a family is forced by a stressor to make a change in its established patterns. Inappropriate patterns are reorganized and modified. A crisis consists of the events associated with the family's necessity to change and

a potential difficulty in doing so. Families develop patterns of action and interaction over time and these patterns require revision as the family or its environment changes (Montgomery, 1981).

The concepts stress and crisis tend to carry negative connotations but the two can be associated with positive consequences as well. A crisis can chart new developments, new coping mechanisms, especially if the problem is viewed as a challenge. On the one hand, a crisis such as cancer can be faced with anger, built up tensions, hidden thoughts and unresolved feelings. As well, the crisis can lead to positive growth and experiences. It can give a whole new philosophy for living, not only for the patient, but for family and friends as well. Just realizing that it has struck close to home can change one's outlook on life. It forces one to come to terms with the concept of death. One can find a renewed beauty in living and it gives life a new quality and value. Mutual support, communication, honesty and openness can help work through the ordeal (Regush, 1981). Most often, rather than having the two extremes of destructive or adaptive growth orientation, families tend to move along a continuum, working through the hard and tough times as well as the better times.

Various factors influence the outcome of a crisis. Previous experience with a similar crisis, the degree of support available, seriousness of the crisis, manner in which family members facilitate or inhibit resolution and

the amount of help available from significant others all can contribute to whether the crisis will present opportunity for growth or danger of deterioration (Moos & Tsu, 1976). Family resources help it to endure, to satisfy the needs of its members and to meet its obligations (Montgomery, 1981).

The stress of coping with cancer disrupts the threads of life. The family must find new patterns and new ways of getting through the days. A family stressor is a situation for which the family has had little or no prior preparation and must therefore be viewed as problematic. The impact of the event depends on the hardships that accompany it. There are some factors which are conducive to a good adjustment to a crisis. Some examples are family adaptability, family integration, affectional relations among family members, good marital adjustment of husband and wife, companionable parent-child relationships and previous successful experience with crisis. Absence of many of these factors leads to poor adjustment (Hill, 1965). Facing the problem as a family, using the sum of the capacities of individual members, role flexibility which allow for a family to retain its equilibrium, and keeping tensions reasonably under control also facilitate good adjustment (Parad and Caplan, 1965).

Schneiderman (1979) believes that the stronger the family unit is, the better equipped it is to deal with the problems surrounding the illness. If there is a good family atmosphere where the parents have been honest with each

other, chances are they may have transmitted their openness to their children, and the children will feel secure enough to go to their parents in times of crisis. Parents and children will be prepared to support and help each other through the stress and strain of the crisis.

Honest communication is essential to lessen the suffering for everyone involved. Families who do well and survive are those with closer and freer relationships between parents and children. This allows for more opportunity for healthy emergence as as individual and for independence to gradually evolve (Kavanaugh, 1972).

A crisis has several impacts on a family. The stressful event poses a problem which by definition is insolveable in the immediate future. The stress of cancer and hospitalization is beyond the control of the family. The members have little knowledge of the probable duration and outcome of the illness. The problem overtaxes the psychological resources of the family since it is beyond their traditional problem solving methods. Feelings of helplessness arise because nothing can be done about the illness. They can only wait, hope and pray for a change. As well, the situation is perceived as a threat or danger to the life goals of the family members. The crisis period is characterized by tension which rises to a peak and then falls. There are good days, especially during a remission period, and there are bad days of treatment and pain. Lastly, the crisis situation can awaken unresolved key

problems from the past which may add to the burden of the present (Parad & Caplan, 1965).

Montgomery (1981) suggests there are four components to a crisis. Firstly, the crisis situation includes a period of time when an inappropriate pattern exists and is not corrected by the family. A family may be swept into a crisis process by unusual circumstances for which they are unprepared. This is the period of incipience. Secondly, the crisis situation includes a stressor event which forces family members to realize that their well being requires correcting the inappropriate pattern. Thirdly, the secondary adjustment period includes the family's struggle to find a more appropriate pattern. Fourthly is the process of reorganization where the family adapts to new appropriate patterns and makes necessary system adjustments to incorporate the new development. In families with a cancer patient, the period of incipience is very short, if it occurs at all. Often things happen too fast and in a life or death situation members accommodate very quickly, and quickly fill in the gaps for what needs to be done in their daily living routine. Steps are taken unconsciously.

There are two ways to cope with stress and crisis (Monat & Lazarus, 1977). Firstly, direct action can be taken such as fight or flight. This alters the relationship with the social or physical environment. Secondly, thoughts or actions can be changed. This relieves the emotional impact of the stress. It allows one to feel better without actually

altering the event. Often a combination of both is used.

Monat and Lazarus (1977) cite a study done by Katz, Weiner, Gallagher and Hellman. Individual differences in responding to stress were looked at in 30 women awaiting breast tumour biopsy. Some women saw the situation as a potential loss of a breast, or even life; some focused on the ambiguities and uncertainties, and others saw it as a test of strength and determination. Individual differences, past history and support resources may account for these different reactions.

Coping refers to two distinct but related tasks- responding to the requirements of the external situation, as well as to the feelings about the situation. The pattern has two phases, an acute phase in which energy is directed at minimizing the initial impact of the stress, and a stage of reorganization in which the new reality is faced and accepted. In the acute phase, feelings may be denied while attention is directed at practical matters. This allows for time to adjust to the change in one's life. The reorganization phase involves the gradual return to normal functioning and reintegrating new feelings and circumstances into one's life. It allows for the achievement of a new equilibrium (Moos & Tsu, 1976).

Caplan, cited in Moos and Tsu (1976), states seven characteristics of effective coping behavior.

1) Active exploration of reality issues and search for information.

2) Free expression of both positive and negative feelings and a tolerance of frustration.

3) Active invoking of help from others.

4) Breaking problems down into manageable bits and working them through one at a time.

5) Awareness of fatigue and tendencies toward disorganization with pacing of efforts and maintenance of control in as many areas of functioning as possible.

6) Active mastery of feelings where possible and acceptance of inevitability where not. Flexibility and willingness to change.

7) Basic trust in oneself and others and basic optimism about outcome.

A study on the effects of stress of an illness on a family was done by Cohen, Dizenhuz and Winget (1977). Results showed that there is a significant correlation between the free flow of information within a family and the utilization of internal support systems. The more that family members were able to communicate with one another, the greater the likelihood of an effective adjustment during the postdeath period. There was a reluctance on the part of the family to discuss the seriousness of the illness and impending death with the children. When asked who helped the most, younger children said it was the surviving spouse, older children turned to a friend, and the surviving spouse turned to other relatives or to an agency, for example, Cancer Family Care. Finally, for teenagers and young adult

children, social life was the area most changed. Parents reported an increase in health problems.

As indicated, families are so closely knit that changes in one member affects and has implications for the family as a whole. If, for example, the wife/mother has cancer, it can be assumed that for a certain time period, she will be unable to fulfill some functions within the family repertoire. Other members will be needed to pitch in and help out. Even a family who is very close may find itself divided. There are three types of family reactions to illness (Calhoun, Selby & King, 1976). The first is the growth response. This is characterized by the family pooling resources and working out the most constructive solution through open discussion. The second response is breakdown and then rally. There is constriction of outside contacts, confusion in communication among family members. The family will eventualy begin to make positive changes and begin functioning in a constructive way to solve problems presented by the illness. Lastly, the family may encounter more and more difficulty functioning. Further, families who cope effectively are those who were healthy before the onset of the cancer. They will have clear separation of generations, flexibility within and between roles, direct and consistent communication among family members, and tolerance of individuals within the family.

Transition and Change

The onset of cancer often precedes a time where the individual and significant others in his/her life go through some changes in their current lifestyles. Most of us experience surprises, or disruptions in our lives; some are intentional, others are not. A life transition represents a discontinuity in one's routines and in one's life space. It is a disruption of the homeostatic equilibrium. It causes a movement from one relatively stable state to another (Parad & Caplan, 1965). Often, fears are associated with a transition. There is a transition from a state of relative security and a familiarity of the present to an insecurity and uncertainty of the unknown and potentially threatening future (Pearson, 1969).

An essential aspect of a system is to return to a state of equilibrium after being disturbed by a stress or crisis. Most stresses studied involve physical change or partial incapacity of at least one family member. The structure or status of the family is changed either slowly or abruptly. The family is forced to make new definitions of its situation and to assign new roles (Hill & Hansen, 1964).

Montgomery (1981), suggests that there are two types of changes a family can go through. First order change is when a family revises its patterns in order to maintain the family system rather than to revise it. Behaviour changes at

one level but higher level values remain stable. The system remains the same but there is a change within the system. It is a more mild transformation than second order change. This is when there is drastic change and a new family emerges different from the one that existed before, with new structure and new interaction patterns. There is a change in the system's structure, or basic values. There is a major change in the family's way of life.

Prolonged illness of a parent means that certain role responsibilities can no longer be managed as they have been in the past. How changes are made will be influenced by the family's pattern of functioning, for example, how roles are defined, how tasks are assigned, the stage of family life, and the patterns of communication. Habitual family roles become confused. First, the family may become manipulative in its attempt to restore the status quo. When this fails, it may resort to role reversal. New roles are worked through until they fit the family situation. Ultimately a new balance is achieved. Cancer in a family member can cause changes in status within the home, changes in role evaluation, in the strength and direction of feelings between members, maintenance of discipline and performance of routine duties in the household (Anthony, 1969).

Depending on which parent has the illness, different transitions occur. Traditionally, illness in a husband-father may bring about relevant changes in the household which the wife has to get accustomed to. She may

feel threatened by the loss of security and the end of her dependence on her husband. She will take on chores previously done by him. She may have to get involved in business matters and financial affairs. The family may have to adjust to a worsening of their standard of living (Anthony, 1969). As well, people depend on the husband/father to play his role. He may also be part of various political social or religious organizations (Pearson, 1969).

Illness in a wife-mother causes a different type of change within the family. The husband has to concern himself with matters regarding the children, school, after school activities, meals and clothing. Mostly, household chores still have to be done. New roles must emerge. Often children take over some of the adult functions (Anthony, 1969; Kubler-Ross, 1969; Pearson, 1969).

A change triggers a cycle of reactions and feelings. There are seven phases to a transition (Hopson & Adams, 1976). The first phase is immobilization. One has the sense of being overwhelmed, unable to understand, make plans or reason. Everything is a function of unfamiliarity and of the negative expectations one holds. If the transition is not a high novelty, or if positive expectations are present, then the immobilization is less intense. Phase two is minimization of the change. One denies that the change exists. This is a normal and necessary reaction to an overwhelming crisis. Thirdly, depression sets in. One

becomes aware of the realities and must face up to the change. Often this phase is associated with frustration since it is difficult to know how to cope with new life requirements. Next is accepting reality for what it is. One needs to let go of the past and deal with the present. The testing phase includes trying out new behaviours, new life styles and new ways of coping. Phase six is seeking meanings. One tries to understand how things are different, why they are so, and the meaning of the change in their lives. Lastly, there is internalization when people incorporate these new meanings into their behaviour. In sum, the seven transition phases represent a cycle of experiencing a disruption, gradually acknowledging its reality, testing oneself, understanding oneself, and incorporating changes into one's behaviour. A person does not neatly go from phase to phase but may skip or stay in one for a longer time.

Two tasks accompany a transition (Hopson & Adams, 1976). One is the management of strain so that the individual can engage in the external problems caused by the transition. This includes having someone to fall back on, filtering out certain stimuli, congregating with others experiencing similar strains, seeking professional or interpersonal resources and having support systems. The second task is a cognitive one. One must make decisions about appropriate new behavior patterns and adjust accordingly.

Summary of Related Literature

Cancer, a life threatening illness brings out some of the strongest emotions in the patient as well as those close to him/her. A variety of stages are passed through as one learns to adjust to the illness. Denial, anger, depression, withdrawal resulting in isolation, grief and fear are among the most common. Finally, a stage of acceptance is reached where coping mechanisms allow the patient and his/her family to adapt to their new situation. From the time of the initial diagnosis, the family may experience positive feelings: love, intimacy, support, and strength, as well.

The cancer illness not only affects the patient, but also has significant consequences on the family. A family is viewed as an interpersonal system. Each member's behaviour affects and relates to that of the others. Established patterns and rules will be broken forcing the family to accommodate to a new set of behaviours and establish a new equilibrium for itself.

Within a family context, interaction and communication are always present. One type of interaction pattern which defines relationships is symmetry and complementarity. Symmetry is based on 'sameness' while complementarity is based on 'difference'. Most commonly, both are found in any one relationship.

Once the family accepts the realization of the illness, it is then ready to begin coping effectively with the new set of circumstances. Old, inappropriate patterns are revised, reorganized and modified. Factors facilitating good adjustment include flexibility, good support systems, honesty and openness, and direct and consistent communication. A family will move through the transition period, where changes will occur, and then settle into a new more comfortable homeostasis.

Methodology

General Procedure and Design

Data were obtained via a descriptive case study approach. This method provides a detailed account of a phenomenon and allows for a more in-depth investigation of a process. A case study is exploratory in nature and due to flexibility in questions and responses, and minimal control, circumstances are permitted to develop naturally (Neale & Liebert, 1980).

Since it is recognized that the interviewer is an important instrument in the session with each family and may affect the data obtained, pilot studies were conducted beforehand. The interview procedure was practiced with nonsubject families. This was beneficial as feedback regarding the interview schedule and the refining of any unclear questions was obtained.

A semistructured interview was conducted with two volunteer families. The procedure was a self report study and was of a phenomenological nature. Interviews were held at the University of Alberta and in the family's home. All interviews were audiotaped.

Subjects

Subjects were located through the aid of the agency Cansurmount, which is a support group for families with cancer. The writer called the agency and introduced the intended research to a volunteer worker. She then explained and proposed the research at a group meeting and asked for volunteers who were interested in partaking in the study. Many people responded. However, as most were single, and the study's focus concerned families, they were ineligible for inclusion in the study.

The subjects consisted of two volunteer families, each having an adult member who had been diagnosed as having cancer within the past five years. The individuals with cancer were two females. The first was married and had four children. She had a mastectomy about three years ago (hereto referred to as the A. Family). The second woman was married but had no children. She had cancer of the cervix (hereto referred to as the B. Family). Both cases dealt with a very specific type of cancer. Both women had had surgery and were told they were 'cured'. Therefore, neither family was adjusting to a terminal cancer.

Interview Schedule

A semistructured interview was designed to cover the following four areas (Appendix A): 1) medical data and

background, 2) family data and background, 3) changes since diagnosis in fulfilling various functions within the family, and in relating to one another, and 4) facilitators to changes. In addition, a follow-up interview was conducted with the A. Family in an attempt to learn more about interaction patterns within the family (Appendix B). This was done with one family only as the second family consisted of just two members and the interview would have been inappropriate.

Whenever possible, the interview was conducted via methods proposed by Selvini, Boscolo, Cecchin and Prata (1980). Family members were asked not only about themselves, but about other members as well. Members were asked to speak about how they see the relationship between two other members. For example, the daughter may be asked how she thinks father's and mother's relationship has changed. This is an investigation of a diadic relationship as it is seen by a third member.

Three principles in interviewing families were put forth by Selvini et al. (1980). Hypothesizing is the formulation of a hypothesis based on information about the family. This serves as a starting point of the investigation. An hypothesis is a guide to providing new information which will be confirmed, refuted or modified. Circularity is the capacity to interview on the basis of feedback from the family in response to information about relationships and changes. Different answers will elicit

different follow-up questions. The third, neutrality, is the effect of the interviewer on the family. For example, sides should not taken. The interviewer would not say whether changes were expected or not.

Data Collection

In the initial telephone contact, both families were provided with a description of the research being done and what their participation would involve. At the interview session a consent form was signed and permission to tape the session was obtained. Recording the interview was necessary for subsequent analysis of data. Confidentiality and anonymity was assured. Every effort was made to establish good rapport with the families. Family members were informed that if they preferred not to respond to a question, or did not want to discuss an issue, the interviewer would respect their request.

Data Analysis

Audiotaped recordings, verbatim transcripts, observations and impressions of the interviewer were analyzed. As well as noting the content of responses to specific questions, style, communication and interactional patterns were explored. These patterns were then related to changes the families have gone through resulting from the

cancer. Patterns of symmetry and complementarity received particular attention. Based on the data, rules existing in each of the families were inferred through the interviewer's observations of set patterns of responses and behaviour.

Findings

Interviews with the two subject families were completed in January and February 1982. Each averaged approximately 1 1/2 hours in duration. In addition the A. Family was interviewed a second time in March. The A. Family was interviewed in their home and the B. Family was interviewed in the University of Alberta clinic. The interviews were explored through a case study format. Family background and information and responses to questions are included in the case presentation. The abbreviated headings of Mr. A., Mrs. A., and D. will denote the father, mother and daughter respectively in the A. Family; Mr. and Mrs. B. will denote husband and wife in the B. Family and I. will denote the interviewer.

The A. Family

Changes Resulting From the Cancer Diagnosis

The A. Family interview was attended by Mr. A., aged 48, Mrs. A., aged 43, and a married daughter, aged 20. A second daughter, aged 15, was unwilling to participate. Two sons, aged 25 and 22, live out of the province and were therefore unable to participate. Mr. A. has a grade eight education followed by four years of trade school and is presently employed as a boiler maker. Mrs. A. completed grade 10 and then later returned to school taking night courses for grade 11 and 12. She is presently working in a school for native children teaching and counselling. The daughter who was present has completed grade 12 and works for the Alberta Liquor Commission Board. Mr. and Mrs. A. have been married for 20 years. Mr. A. and the daughter are Catholic but neither observe his/her religion. Mrs. A. is a member of the native religion and follows the traditions to a great extent, especially in the past four years since her cancer diagnosis. Mrs. A. was diagnosed as having breast cancer in June, 1978. She was immediately admitted into the hospital for a biopsy which was quickly followed by a mastectomy. The duration of her stay in the hospital, including surgery and recovery, was three weeks.

The A. Family has had experience with illness in the past. Mr. A. had a back operation about six years ago and was in and out of the hospital for two and a half years. Following this he spent another two and a half years at home. As he was unable to work for a total of five years, the family experienced financial difficulties during this time.

Little if no financial change was felt by the A. Family during Mrs. A.'s illness. Mrs. A. had been working before the cancer and had the operation over the summer holiday. She did not get paid over the summer, and she had some sick time coming to her as well. After the summer, she went back to work. D. mentioned that, "She went back to work a little too early. She needed to feel a part of everything again." Mrs. A. was sick when she first returned to work. She could not lift things, for example, cases and books, but still persisted.

Mr. A. stayed home for three months after Mrs. A.'s operation. He helped out a lot particularly for the first two months during her recuperation period. Mr. A. drove the children to wherever they needed to go. The children did their homework on their own. They were generally quite independent. There is an indication of change in this area.

The whole family cooperated in doing the housework; cleaning, dusting, vacuuming, and a washing machine was bought as soon as Mrs. A. got ill. They did the grocery shopping together. Mrs. A. would go along, but she was

unable to reach products on the shelves. There was no change in who did the cooking as Mr. A. did most of it even before the cancer. D. commented: "What was nice was we all got to work together for once." Mrs. A. did most things before she got ill, but Mr. A. and the two daughters all helped out after. Mr. A. said, "It all happened so fast. Today we would never know it's happened." Working on the house kept Mr. A. busy. Therefore, there were some changes in household duties.

For the first month there was not much humour or laughter heard, but then they were able to kid about the situation. Mrs. A. liked to tease and was able to regain and maintain a sense of humour. At the same time, when Mrs. A. could not do something, or reach something, she got depressed and cried.

> D.: "For the first month she was very depressed, wanted to be alone, didn't feel right any more. She didn't feel all there I guess. Then she said to heck with it. She was going to go out and ever since she does anything she wants to."

It appears that it was during the first month that much of the adaptation to the illness occurred. It was during this early stage when Mrs. A. seemed to learn to accept the cancer and decided that she must still continue with her life and assert her independence. When D. was asked if she noticed any change in her parents, she replied that

> "There was a big change in them. Dad was very over protective and always wanted to know where she (mom) was going. There was a big change afterwards because mom said 'I'm going out and doing it for myself.' Dad had to get used to that. I think it was for the

> better. They also got to know each other better at that time. It brought them closer."

Mrs. A. said that she is more independent, that she will buy things that she likes even if Mr. A. was not there. She comes and goes more as she pleases now.

With regards to gift giving, Mr. and Mrs. A. were going to buy D. a gift for being so helpful but decided not to. One day when she needs them, they will be there for her. Mrs. A. said

> "D. was very good to me after my operation, cleaning me, or she would come and rub my back. When I was feeling sorry for myself she would tell me to stop it."

D. spoke of her younger sister at this time.

> "It bothered my sister when mom got sick because dad was in the hospital so much. She wanted to go but started to hate it. She just doesn't like going to hospitals."

Mr. A. was at the hospital every night. Both Mr. and Mrs. A. said that there were no changes in sexual relations and no effect on personal body image.

For emotional support, D. usually went to her boyfriend with anything on her mind. If she went to a parent, it was her mom. This was true for before and after the cancer diagnosis. Therefore, there was no major change in this area.

In the areas of decision making, there were changes in only one, that being the finances. Mrs. A. will now buy more things and spend on herself more.

> Mrs. A.: " I feel now if I want it, I'll buy it."
> D.: "Mom felt guilty before, that the money could be put to better use, but then she felt, hey it's me, I could have died. I am going to enjoy what I got left."

Again it is evident how Mrs. A. now put herself first and began feeling that she too is important. In terms of parenting, Mrs. A. did the disciplining both before and after the cancer onset. Mr. and Mrs. A. rarely took holidays except to visit her parents at the reservation. However, after the cancer, they went to Europe to visit Mr. A.'s family.

The major change in religious beliefs was for Mrs. A. who began to observe her native religion more following the cancer. Before she believed in it, but now she takes a more active part in it. She said, "The native religion is dear to me." This firmer belief may relate to her change in values with regard to her now being able to do more things for herself. Mr. A. and D. now understand more when Mrs. A. practices her religion.

Mr. and Mrs. A. did not go out socially very much before the cancer, nor do they after. They usually keep to themselves. The slight change is that they may go out for breakfast together now more than before. There was a difference in how friends approached Mrs. A.

> Mrs. A. "Some would just look at you as if to say how long does she have? Most friends were very good to me. Some didn't say the word (cancer). Some felt sorry."
> D.: "But good true friends showed no difference. They joked and laughed with her."

Generally, friends were very supportive.

There were no increased fears or feelings of vulnerability for any members in the A. Family.

In terms of changes regarding life outlook, Mrs. A. said she "is now stronger, more bolder to go out there and face things." She added: "I feel life is too short." Before the cancer her major concern was just wanting the kids to grow up.

> D.: "She was putting more into us than she was into herself. After the cancer she put more into her than into us. Now she is number one."

Again the issue of Mrs. A. asserting her independence surfaced.

Mrs. A. thought she may not see her students in her classes again. She went out of her way and took an extra interest in them. For example, she taught the other teachers to give the children a hug and to let them know they cared. Mr. A. and D. realized they would have to face the cancer right away and deal with it. That is what they did. When the interviewer summed up by saying that Mrs. A. approached life differently, puts more into herself, taking more care of herself, has grown from the cancer and that the changes have been positive, Mrs. A.'s immediate response was, "Oh yes."

The relationship between Mr. and Mrs. A. stayed pretty much the same after the cancer. They were still as close as before, but both have become more independent. D. mentioned that Mrs. A. took care of things in case she died. She asked D. to be kind to her step-mother if Mr. A. ever remarried She also left a note of who to send Christmas cards to.

There was no change between Mr. A's and D.'s relationship, or between Mrs. A.'s and D.'s relationship.

Extended family was not around much during the time of Mrs. A.'s cancer. Friends were very supportive as were Mrs. A.'s co-workers, one in particular. It was clear that most of the support and helping through the crisis came from the immediate family. D. received a great deal of support from her boyfriend. When Mr. A. was asked who he turned to, he said he helped himself. He kept busy with work around the house and relied on his own strength. D. jumped in at this point and said that Mr. A. was absolutely lost when Mrs. A. was in the hospital. He was lost until Mrs. A. was back at home. For example, Mr. A. is colour blind and had difficulty choosing what clothes to wear.

Cansurmount was a helpful service for Mrs. A. She described the meeting as a place where she could talk to someone else who really understood, listen to others in the same situation and know that she was not the only one feeling like she was. Mrs. A. now helps others who have had a mastectomy, especially natives because she speaks two native languages. She enjoys being able to help others. She knows it is a lonely journey and she has to be strong herself to help others.

Interactional Patterns Reflecting Symmetry

Symmetrical interaction patterns were very evident between members of the A. Family, especially between mother and daughter. There was constant agreement between Mrs. A. and D. to the point where one would finish the others sentence, knowing that they were thinking alike. The following exchange was in response to a question regarding family finances and Mrs. A.'s employment.

> Mrs. A.: "I usually don't get paid July and August anyway."
> D.: "Plus she had a lot of sick time. She could have taken September and October and still got paid for it."

A further illustration of this pattern was:

> D.: "She went back too early because she was really sick there for quite awhile."
> Mrs. A.: "Yes, I couldn't lift and in my job I have to lift, suitcases, books."

Another example of Mrs. A. and D. illustrating symmetrical interaction occurred when discussing household chores.

> Mrs. A.: "I used to be so fussy before. I don't think I would have lived like this."
> D.: "No. Everything had to be perfect. Everything had to be absolutely spotless."

Mr. A. often brought up how quickly the experience passed and how everything happened so fast. On one occasion, D.'s reiteration of his words were indicative of symmetry.

Mr. A.: "It happened so fast. Today I'd never know it happened. There was so much work to do in the house, there was nothing to think about."
D.: "Ya. She was in and out so fast. It was just over and done with."

Confirmation was the style between Mrs. A. and D. throughout the interview. When Mrs. A. was discussing how she felt going through the crisis, D. was able to recognize and empathize with these feelings, both during the time of the cancer, as well as during the interview, and help her through her times of depression.

Mrs. A: "When I knew I couldn't reach it (referring to a high part on a door) so I said, in two days time I'm going to reach it. If I didn't, I remember standing there and crying."
D.: "Ya, she couldn't reach it."
Mrs. A.: "Or I cried when I watched her take her scarf off. I thought I would never in my life be able to do that." (lift arm over head.)
D.: "You did that. There were hard times when you still got depressed."
Mrs. A.:"Yes. At times my arm would swell up, or my purse wuld be too heavy."

Occasionally the symmetrical interaction between Mrs. A. and D. was evident by both completing the other's comments and by responding the same way at the same time. The following interchange took place when discussing changes in religious beliefs.

Mrs. A.: "The native religion is very dear to me."
I.: "Was it as dear to you before the cancer?"
Mrs. A. and D. (together): "No."
D.: "She believed in it..."
Mrs. A.: "But I wasn't taking a major part in it."

Completing each others sentence was further evident when speaking about the positive effects of Cansurmount.

Mrs. A.: "It was one of first times that you can talk to someone else..."
D.: "Who understands, who really understands."
Mrs. A.: "Yes."
I.: "The group has been helpful, listening and talking with them!"
Mrs. A.: "Yes. Just listening to them talking. I wasn't the only one feeling this way."
D.: "Yes, she felt really good. She talked about it for weeks."

There was just one occasion where all three family members were taking part in symmetrical interaction. This occurred at the end of the interview when briefly discussing the younger daughter who was not present.

D.: "She was the major change in the whole family."
I.: "It's unfortunate she was not here. I would have liked to hear what she had to say."
D.: "She wouldn't have said anything."
Mrs. A.: "I don't think she would have said anything."
Mr. A.: "She would just sit at the table."
Mrs. A.: "Thinking may I leave now."
D.: "You wouldn't be able to get through to her."

Interactional Patterns Reflecting Complementarity

In any complementary interaction, it was Mr. A. who adopted the one-down position with either Mrs. A. or D., or both taking the one-up position. Often Mrs. A. and D. would, in the same exchange, be symmetrical with each other, while complementary with Mr. A. When Mr. A. was asked if he helped take over some of the child-rearing chores, it was Mrs. A. who responded.

Mrs. A.: "Yes. He stayed home right until October,"
Mr. A.: "I stayed about a month."
Mrs. A.: "Oh you stayed home three months."
Mr. A.: "Three months?"
D.: "Ya. You stayed home the whole time mum was home."

A similar type of exchange happened as well when discussing a vacation the family took together.

D.: "We went to California when we were really little."
Mr. A.: "You were about 12 or 13."
Mrs. A. and D.(together): "Oh no"
D.: "I was only nine."
Mr. A.: "You were older that nine."
Mrs. A.: "When we went, we stayed a month."
Mr. A.: " Over a month."

On one occasion Mr. A. and D. were discussing where Mr. A. would go for support. There was disagreement, with both of them unwilling to let go of their own point of view, neither one giving in to the other.

I. (to Mr. A.): "Who did you go to for support?
D.: "He was lost for a little while without mum."
Mr. A.: "I was never lost."
D.: "You were so."
Mr. A.: "I was so busy...with my work."
D.: "You were so lost. How many times did you sit downstairs and walk around and not really know what to do with yourself?"
Mr. A.: "No, no, no."
D.: "Oh ya, my dad was sort of lost."
Mr. A.: "No way."

Follow-up Interview

An additional interview was held with the A. Family (Appendix B). This interview technique required at least three members and therefore was inappropriate for the B. Family. The purpose of this second interview was to attempt to get a clearer picture of the process and relationship between family members.

When D. was asked how she saw the relationship between her mother and father, she responded:

> "They get along. It has changed quite a bit since mum had her operation because dad always had to know where mum was going constantly and now, mum just goes when she feels like it. They still get along though. Oh ya."

Mrs. A's response to how she saw the relationship between Mr. A. and D. was,

> "Oh, I think they get along okay. D. just has no patience that's all."
> D. added: " Ya, no patience whatsoever."

Mr. A. described the way Mrs. A. and D. get along as "Fighting all the time. Both are stubborn. That's the only problem. No one wants to give a little bit."

Each member was asked which two people in the family do the most arguing and the least arguing. There was unanimous response on these questions. Mrs. A. and the daughters argue the most, and Mr. A. argues the least with with all members. When asked who did the most reprimanding when a problem occurs, D. answered that mum did most of the correcting and

disciplining but Mrs. A. added: "Mr. A. pretends to be boss. We let him feel he is boss".

Family Rules

On the basis of family interaction patterns, the following rules can be inferred about the A. Family. 1) In a conflict situation, Mrs. A. seems to assert herself and usually wins in the spouse/parental relationship. 2) Mrs. A. expresses herself emotionally while Mr. A. expresses himself rationally. 3) In the case of a behaviour problem with a child, Mrs. A. initiates the appropriate action while Mr. A. observes the process. 4) Open disagreement between members is allowed to be expressed. 5) Members are allowed to express themselves freely. 6) Family members can express themselves and are heard by other members. 7) A common and accepted way of relating is through humour. 8) When family members are not present they are hardly mentioned.

The B. Family

Changes Resulting From the Cancer Diagnosis

The B. Family interview was attended by Mr. B., aged 31, and Mrs. B., aged 26. They do not have any children. Mr. B. has a grade 11 education and is a self employed painter. Mrs. B. has two years university and is presently taking night courses in personnel administration. She works for a large company in the personnel department. Mr. and Mrs. B. have been married for eight years. Both are Protestant, but neither follows or observes his/her religion very closely.

Mrs. B. was diagnosed as having cancer of the cervix in August, 1980. She began treatment with radiation inserts, then underwent surgery to remove affected lymph nodes and tissue, and continued treatment with external radiation. The whole procedure lasted for about four months.

The B. Family had experienced previous illness. Mrs. B.'s father had lung cancer and died about seven years ago.

The B. Family experienced no major change in financial status. Mrs. B. returned to work as quickly as possible. During her absence, she was covered by a generous health plan and salary replacement.

In terms of household duties, while Mrs. B. was in the hospital, few things got done. Mr. B. often ate out, usually at the hospital. He said: "Good food was the furthest thing

from my mind. It wasn't important." Cleaning went right by and was not bothered with. Mr. B. would just do the basics. Little laundry was done and since meals were not eaten at home, there was little grocery shopping to do. After Mrs. B. returned, she said there was no change in this area especially since both worked before the cancer diagnosis. "We were used to alternating. If one was stuck for doing something, the other person helped." Household duties appeared to fade into the background during the cancer crisis.

Due to the type of cancer, there was a definite change in Mr. and Mrs. B.'s sexual relationship. There was a significant decrease during the illness period. This was of little concern to Mr. B. He said: "It was the least of my worries at the time." There was little laughter in the B. household during these few months. Things were very serious. Again, the expressed concern over the cancer was indicated. All else seemed unimportant at the time.

An outlet for Mr. B. was to read a great deal. Mr. and Mrs. B. were able to talk about the situation quite openly. A recurring topic at that time was the fact that Mrs. B. could no longer have children. This was not as much a concern as just knowing and resenting having a choice taken away from them. They were unsure as to whether they would eventually have children, but now they know that they will not. They chose not to go through the adoption process.

Before the cancer onset, Mrs. B. made most of the major decisions. She was the one who made sure the bills were paid and social contacts were maintained. During the cancer period, Mr. B. took over these duties, but after the cancer, Mrs. B. quickly resumed her position. She commented:

> "I always like to be in control, the dominant one. For a few months it changed. It shifted a lot of extra responsibility to Mr. B., for example, taking care of the bills, the dogs, and running the household. It was very difficult to accept the fact that for so much time I had to relinquish the control to someone else."

This shift of responsibility seemed to be the major change for the B. Family.

There were no changes in observing their religious faith for either Mr. or Mrs. B.

In terms of social relationships, when asked if friends approached them differently, both quickly answered, "Oh yes, definitely." Some friends maintained contact while others completely ignored them. A very close friend, in particular, who Mr. and Mrs. B. expected to be very supportive and to help out, did not even go to the hospital. The friendship seemed to drop off completely. Another friend who disliked going to hospitals, "seeing it was Mrs. B., forgot about his hangups and went anyway." Many friends did not offer encouragement and did not even say anything. Mr. B. has no family in the city, while Mrs. B. has a mother and a sister living here. However, her mother never went to visit her and her sister only rarely went. Closer friends seemed to back off whereas more distant friends and co-workers were really

there when they were needed. They cooked, brought care packages and visited. Mrs. B. commented: "People at my job were probably the best out of the whole bunch." Mrs. B. said that not having people around "was more difficult for Mr. B. to deal with because I was sick and there were days when I really didn't care who was there and who wasn't. He had nothing, had a lot of things to do." Mr. B. summed up by saying, "Not too many people got points but there were some who I really appreciated, who did things that surprised me."

When asked if there has been any increase in fear or vulnerability since the cancer, Mrs. B. said,

> "I feel more vulnerable, but not to cancer. Your bones get brittle and your skin dries out. Certain things happen to you after surgical menopause. I was never afraid I was going to die. I picked up life where I left it."

There has been no change in this area for Mr. B. He believed that it might happen to someone else, but not to him.

Mrs. B. said she would not really approach life any differently now.

> "If I was afraid I was going to die, I'd change my life, but I'm not. If I were single, I might go full speed ahead, be more adventurous, but there is a family unit to be maintained. If I had the feeling I was going to die, I'd take more risks."

The relationship between Mr. and Mrs. B. did change as a result of the cancer. Mrs. B. said they have grown from the experience and explained that they went through three phases.

> "At first when I found out I was ill we were close. Then I went back to work. It was too soon but I was stubborn about it. There was no way I was going to be off work a minute longer than the actual treatment. I denied the whole business. I'm not ill, I'm not sick. It's an easy thing, it will take this much time and I'll be back. Nothing to it. When I first went back I was too tired to work but refused to stay home. I got more and more exhausted. I also went back to university classes at night. I tried to pretend it never did happen. At that period of time, by the end of six months we drifted apart. All my energy was channelled into getting to work and through the day. Then I got home and collapsed. We weren't communicating all that well. If the Cross(Cancer Institute) had said don't go back to work for three months, it would not have happened. You go through a period when you feel so rotten you don't ever think you'll be healthy again for the rest of your life. Then I took two months off from work and that made all the difference. Now we are okay."

Mr. B. agreed with her description of the transition. "After there was a little bit of distance between us. I think we have gotten closer now, more sincere with each other."

When asked where Mrs. B. got most of her support, her response was, "My husband, most definitely." There was not much support from family or friends. Recently she has begun to go to Cansurmount and said their service is a great idea. Mr. B. said his support came from "No one really, maybe one or two good friends, but mostly myself." As well, the psychologist at the Cross came into the picture when Mrs. B. took time off work. "She was very helpful, someone who can listen, facilitate and initiate us to talk. We were able to bounce things off her." Mrs. B. started seeing the psychologist herself, and then Mr. B. joined the sessions.

Mrs. B. commented at the end that a significant change for her was that she is not as strong as she was,

physically. She lost stamina and her body cannot keep up with her. They even got a cleaning lady to help out with household duties. Mrs. B. said she learned to enjoy detective novels which saved her while in the hospital. It was a way of escape, a way to occupy her mind. She continues to read them now. Lastly, she said, "One thing that has been taken away is a family, so if I was career-minded before, I'm twice as bad now." At the same time she realized that a job is not everything and you need to fill in other things in your life.

Interactional Patterns Reflecting Symmetry

Throughout the interview with the B. Family, symmetrical patterns were evident. One was constantly backing up and confirming what the other was saying. When discussing who took care of some of the household chores, the following interchange took place.

Mr. B.: "Food wasn't thought of."
Mrs. B.: "We ate when we had time."
Mr. B.: "It wasn't important."
Mrs. B.: "Ya."
I.: "What about cleaning, vacuuming, dusting...?"
Mr. B.: "That wasn't important."
Mrs. B.: "No. That was one thing that went right by. We didn't bother about it."

This type of communication pattern was consistent through the entire interview. Another good example occurred when talking about who made more of the decisions and held

more of the responsibilities.

Mrs. B.: "I'm usually in control."
Mr. B.: "She's the dominant one."
I.: "This changed for five or six months ?"
Mr. B.: "Yup. I'm not much for paying the bills. I'll confess, she pays the bills."
Mrs. B.: "I do look after the bills."

When the two were discussing social relationships, again one agreed with the other. As different friends were brought up, they were in agreement about who was supportive and who helped out the most.

Interactional Patterns Reflecting Complementarity

There was just one instance where Mr. and Mrs. B. did not agree. The following exchange illustrates this.

Mrs. B.: "My mother didn't come visit me."
Mr. B.: "Her mother didn't come and her sister didn't..."
Mrs. B.: "No, my sister did."
Mr. B.: "Well...but from the time you were there she never hardly came at all."
Mrs. B.: "Oh, but they are very busy."
Mr. B.: "Well O.K. It doesn't bother you, it doesn't bother me either. But that's the way it was."
Mrs. B.: "I find it much stranger that a mother wouldn't come. She had a negative experience." (referring to her father).
Mr. B.: "But she's always bothered us and always said that we never visited your dad. But then did the same thing to you. I don't understand that."

It appeared as if the above area of disagreement had come up before. Mr. B. would have liked more support from his wife's family to help him through the crisis, but never got it. Mrs. B. feels that she has to defend them for not

being around.

Family Rules

On the basis of family interaction patterns the following rules can be inferred about the B. Family. 1) In interactions between Mr. and Mrs. B. it is assumed that Mrs. B. will take the lead. 2) When discussing the cancer crisis, it is more appropriate to interact on a rational level rather than on an emotional one. 3) In the spousal relationship, disagreements are set up as to allow Mrs. B. to win. 4) Flexible boundaries are maintained as to allow each to do things independently of the other. 5) An accepted way of relating is through humour. 6) It is acceptable for participants to express themselves freely.

Comparison of Changes Between the Two Families

There were both similarities and differences evident between the two subject families. Each of the areas in every day living is presented.

In terms of financial changes, neither of the families was affected. Both husbands were working. Mrs. A. had the operation during summer break, and Mrs. B. was covered through the company health plan. As well, neither was out of commission for an over extended period of time. It was interesting that both women expressed a need to return to work as quickly as possible, even before they were really ready and strong enough to start.

The area of child-rearing applied to the A. Family only as there are no children in the B. Family. For the A. Family there were only minor changes. Mr. A. was around more to help out for the first two months as he took time off during Mrs. A.'s recuperation period.

Both families handled household duties quite differently during the illness period. A change for the A. Family was that as Mrs. A. was unable to do the chores, the whole family pitched in together and got them done. New roles emerged with the children taking over some of the adult functions (Anthony, 1969; Pearson, 1969). For the B. Family, household duties became unimportant and irrelevant. There was little regard for these types of details. If it

was necessary to do something around the house, then Mr. B. would do it. A possible reason for this difference is that for the A. Family, there were two children around. Mr. B., being alone, was not home much and it was not important if, for example, the furniture needed dusting.

In the affection domain, again there were differences for both families. The first month of the cancer was very serious for the A. Family. After this initial period, sense of humour and laughter returned to the household. Mrs. A. had some depressed periods, especially when she felt the loss of control and mastery of her body. This was difficult for her to accept (Rothenberg, 1961). For the B. Family things were quite serious for a longer time. Of course it could be that the B. Family experience justified a more serious reaction.

A more prominent change in decision making was found within the B. Family than within the A. Family. It was the wife in both families who made most of the decisions. In the A. Family the only change was that after the cancer, Mrs. A. was more willing to spend on herself and buy herself things. For Mrs. B., all decision making during her cancer period was transferred over to Mr. B. This was difficult for her as she was used to being the dominant and decisive one. As soon as she was strong enough, she resumed this responsibility.

Following the cancer diagnosis, religion became more important for Mrs. A. She began to follow and observe her religion much more. There was no change for other members in

the A. Family, nor for the B. Family.

Both families faced the situation when it came to social relationships. Friends tended to treat the cancer victim differently. There was disrupted communication, isolation and changes in relationships (Keeling, 1976). An interesting issue which came out when discussing social relationships was that for both families, friends were more helpful and supportive than were members of the extended family.

Neither Mrs. A. nor Mrs. B. had a significant increase in fear with regard to future cancer illness. Both women knew they had to pick up life where they left off before the cancer diagnosis.

There was no major change for Mrs. B. in terms of her outlook in life, or in life's priorities. Mrs. A., however, felt she changed a great deal. She takes care of herself more now rather than directing all her energy towards others. She will go out when she wants, will buy herself things, and has become more independent.

The relationship between family members changed more for the B. Family than for the A. Family. The only change for the A. Family was that they had to get used to Mrs. A. being more independent. Mr. and Mrs. B. had some difficulties with their relationship. Mrs. B. put all her energy into returning to work and her course at university. She had little time for her husband. There may have been a denial component in play. She wanted to go on with her life

as if nothing had happened.

Both families made it clear that the most support came from within the nuclear unit. It was interesting that members of the extended family were not around much to lend a helping hand or to be supportive at a difficult time. Some friends were around, but others seemed to leave the family alone, possibly not knowing how to deal with the situation.

Discussion

The present research explored how families adapted to a cancer diagnosis in a wife/mother, what changes they went through, what facilitated these changes and what interaction and communication patterns were present. As well, a comparison between the two subject families was explored. This will be discussed and analyzed, and limitations and implications for counselling and future research will be presented.

Participation in the interviews was more or less equal among all family members. In the A. Family, Mr. A. may have contributed a little less, and D. a little more with Mrs. A. falling in between. Mr. and Mrs. B. both contributed, Mrs. B. contributing slightly more. This is consistent with the fact that the women in both families appeared more dominant than the men and were in the one-up positions. Interviews were easy going and quite enjoyable with notable humour. For example, the A. Family often referred to comic times in relation to Mrs. A's prosthesis.

All subjects seemed open and honest about his/her thoughts and feelings, were sensitive to each other's needs and were very cooperative. Each listened well to the others and was able to talk directly. There was an expressed warmth and caring feeling. Mutual support among family members was apparent.

Changes Resulting from the Cancer Diagnosis

The literature indicates that families tend to deal with a crisis situation in a variety of ways. Characteristics leading to positive adaptation are cited (Hill, 1965; Kavanaugh, 1972; Parad & Caplan, 1965; Regush, 1981; Schneiderman, 1979). As well, the absence of some family components can lead to a negative adjustment period (Hill, 1965; Moos & Tsu, 1976; Weisman, 1975). Findings in the present study tend to support those describing positive adaptation.

The interviewer's impression of the interview sessions was that both families accommodated well to a nonterminal cancer illness in the wife/mother. Families were flexible and were successfully able to move through the transition period (Hill, 1965; Parad & Caplan, 1965). There did not appear to be any dramatic transformations and changes occurred relatively smoothly.

The success of adaptation for the families can be a result of a variety of factors which influence crisis outcome as suggested by Moos and Tsu (1976). Although they were a different sort of crisis, both families had experienced previous illness and had adjustments to make to a crisis earlier in their lives. As the two types of cancer were nonterminal, the seriousness was not as extreme as a terminal case may have been. Family members facilitated

resolution of the crisis and significant others were available for support. These four factors contributed to the opportunity for growth as a result of a crisis.

Characteristics for good adjustment cited by Hill (1965) have been found, as well, in the A. and B. Families. There was good evidence of family adaptability, affection among members, and successful previous experience with crisis. Role flexibility (Parad & Caplan, 1965), was particularly noted in the two daughters in the A. Family who helped out considerably around the home.

Moos and Tsu (1976), suggest there are two phases one goes through following a crisis. The acute phase consists of denying feelings and directing attention toward practical matters. The reorganization phase involves the return to normal life functioning. Mrs. B. distinctly went through these phases. At first she enveloped herself in her work, with little time for much else. After some time, realizing she was jeapordizing her marriage, time and energy was rechannelled into her personal and social life. Therefore, findings tend to confirm Moos and Tsu's opinion.

Three different types of responses describe family reaction to illness (Calhoun, Selby & King, 1976). It appears that the A. Family responded differently than the B. Family. The A. Family pooled their resources to constructively deal with the situation. The B. Family seemed to initially have more difficulty pulling things together, but eventually began to make positive changes toward a

constructive way of functioning.

Both families went through a first order change (Montgomery, 1981). Patterns were revised in order to maintain the family system similar to how it was before the cancer onset. Following the crisis period, members reverted back to ways which existed beforehand. There were no drastic changes resulting in a new and different way of family life as would occur in second order change.

As system theory suggests, (Watzlawick, Weakland & Fisch, 1974), a change in one family member did affect and cause changes in other members. In the two families presented, these changes did not seem dramatic but were dealt with without major difficulties. Possible explanations for the nonsignificant changes may be that for both families, following the cancer diagnosis, there was surgery and then a recovery period. The illness was not extended over a very lengthy period, but within a few months, family members resumed their previous roles and responsibilities. Furthermore, neither case involved terminal cancer. As well, a crisis period usually involves four to six weeks (Calhoun, Selby & King, 1976). Following this period, efforts are geared toward restoring a homeostatic balance within the family system.

During the interviews with both families, there was joking and laughter. They gave the impression that they were successful at overcoming their difficult times. In support of Kubler-Ross (1969), it appeared as though they had worked

through the initial stages of reaction to an illness to reach the final stage of acceptance. Together, they faced the reality of the situation and dealt with it successfully.

Theories have been put forth to suggest that people actively participate in their own health and recovery. Simonton, Simonton and Creighton (1978), believe that patients who have the will to live and pick up with their lives tend to do well in treatment. Those who feel needed, possibly by their family may have more incentive to recover. This may relate to the easier transition and adaptation process found with both the A. and B. Family. Both Mrs. A. and Mrs. B. commented on how they needed to return to work as quickly as possible after surgery. Both seemed to feel they had to get their lives back in gear and resume their responsibilities.

The above authors suggest, as well, that four steps facilitate recovery. The diagnosis of a life threatening illness allows one to express his/her needs. For Mrs. A., for example, assertive behaviour was now more permissible. New options were open to her, ultimately leading to new experiences. She had recovered her strength and acquired a new sense of control over her life. Her changed behaviour is in support of Simonton's findings.

Managing and maintaining active and mutually responsive relationships was evident in Mrs. A. as well as Mrs. B. Weisman and Wordon (1975), found this to be significantly correlated to survival rates and longevity. Both women were

fortunate to have supportive families and friends. There was an expressed warmth and caring feeling. Mutual support among family members was obvious.

The family system for both the A. and B. families seemed to be stable, flexible and able to accommodate to the crisis situation. However, it must be recognized that in the A. Family, the younger daughter was not willing to participate in the interview. This was unfortunate, for if she was present, different impressions may have been noted. The family said that even if she had been there, she would not have contributed and would not involve herself in responding to questions. As well, it is interesting to note that the two sons who were in British Columbia did not return at any time during the crisis situation.

Interaction Patterns Reflecting Symmetry and Complementarity

Interaction patterns within each family were observed. (Watzlawick, Beavin & Jackson, 1967). Unfortunately as the interviewer did not know the families before the onset of cancer, a direct comparison from before to after the cancer cannot be made. However, inferences with regards to process before the cancer can be made through responses to questions on changes the family has gone through and by examining present interaction patterns. It can be hypothesized that patterns are consistent and maintained before, during and

following the cancer crisis. Findings consistently relate to and support the opinion of Watzlawick et al. (1967).

In the A. Family, it was evident that there was more symmetrical interaction than complementary interaction. This was especially evident between Mrs. A. and D., not only from their spoken words, but through nonverbal communication as well. They maintained eye contact throughout the interview while Mr. A. was more or less on the periphery. As well, the two women constantly related stories and laughed together. Mr. A. spent most of the interview time listening quietly, periodically adding his thoughts about what was being discussed.

In the second interview with the A. Family, symmetrical interaction patterns were again most evident. The most interesting finding from this interview was that it was Mrs. A. and the daughters who tend to argue the most. As both seemed to hold the one-up position in the family, it was as if neither wanted to give in. This supports Watzlawick's and Weakland's view (1979) that competitiveness resulting in quarrels can occur in symmetrical relationships. Neither woman would give in or easily resign to the other. As well, Mr. A. does the least arguing. It appeared as if the females felt that it is not worth the time or effort to argue with him. Mrs. A. said that the family lets Mr. A. feel like he is boss, at the same time implying that he really is not. He does not seem to be the authority figure and tends to fall into the one-down position.

With regards to the B. Family, it was clear that Mrs. B. is the more dominant one in the relationship. However in their interaction patterns in communication, symmetry was much more prevalent than complementarity. The two regularly confirmed what the other said.

In the A. Family, D. seemed to take charge and be in control of parts of the conversation. As well, at the time of the cancer, D. took a similar stance in the family, took care of Mrs. A. and felt responsible to see to it that the family adapted to the crisis situation. It can therefore be inferred that she was dominant and in a one-up position in the family even before the cancer occurred. Mr. A. was often in the one-down position during the interview, often being found in the role of being the submissive one. At the time of Mrs. A's illness, he may have submitted to D., allowing her to take control of the situation. He did not need to assert himself, as things were well taken care of by his daughter. The illness period may have been a good time for him to gain some symmetry in his relationship with Mrs. A., but D.'s quick efficient reaction may have kept him in the complementary one-down position. After the cancer, a major change for Mrs. A. was her being more independent. She seemed to take greater care of herself and even pamper herself. Interactional patterns show her to be the dominant one in the spousal relationship, and in the complementary one-up position. If she was like this before the cancer, her illness made her more so, thus increasing the gap between

her and her husband. When speaking about the younger daughter who was not part of the interview session, the family said she had difficulty dealing with her mother's cancer. It can be inferred that she is the quiet, submissive one in the family, somewhat in the background and on her own, this being consistent from before the cancer onset to the present.

In the B. Family, it was clear through responses to questions that Mrs. B. is the dominant one who takes on most of the responsibilities within the family. By observing interactional communication patterns, although Mrs. B. did most of the talking, a symmetrical relationship was evident. The inference can be made that a similar pattern existed for the B. Family both before the cancer as well as after the full recovery of Mrs. B. During the cancer period, Mrs. B. took over the functioning role of taking care of things, and being more dominant. Based on the premise of complementarity, this was a necessary exchange. If one is unable to perform certain duties, the other is required to pick up the responsibility of doing so (Watzlawick & Weakland, 1979).

In conclusion, by observing interactional patterns within a family following a crisis situation involving cancer in a member, and speaking with each of the families about changes they have gone through, a connection can be made to infer interactional patterns with the family before the cancer. As well, by seeing interaction patterns in a

family before the diagnosis of cancer, one may be able to predict how the family will change and how they will deal with those changes. Interaction patterns tend to be stable across time. If a family member is of a dominant character, and a crisis occurs, it can be hypothesized that this member will tend to dominate the situation and take control, thus assuring that functional adaptation follows. If members are of a submissive nature, there may be no guidance which the family needs to maintain order. This may have implications for counselling with a family to help them through the crisis.

Family Rules

Family rules for the A. and B. Family facilitated adaptation, adjustment and development through the crisis period. Rules generally allowed for flexibility and self expression. Rules governing the A. Family indicated that boundaries between parents and children were not clearly delineated. D. carried out some of the adult functions while Mr. A. maintained his one-down, somewhat peripheral position. Rules for the B. Family clearly indicated that as soon as Mrs. B. was able to resume her reponsiblities following her recuperation period, this transfer was done immediately. They returned to the homeostatic equilibrium, with Mrs. B. in the dominant position, which existed before

the cancer.

Implications For Counselling

Helping a cancer patient and his family improve day-to-day existence can be achieved with increased psychological support, pain and symptoms control and home care, if needed. A few words of explanation by doctors and nurses can prevent considerable anguish. Most of all, honest and supportive families and friends can help the patient and family make a gradual adjustment to the diagnosis of cancer. More harm can be done by avoiding the issue than by using time to sit, listen and share with each other. An acceptance of an unavoidable reality can be met by tuning in to each other's needs, resulting in avoiding unneccessary suffering.

To family therapists, assessment is an ongoing process. Family patterns are observed for hypothesis testing, which guides the therapist toward utilizing specific intervention techniques. The therapist would assess the family's developmental level, its stage in the family life cycle, its unique style, the patterns of interaction and its flexibility in time of stress (Cohen & Wellish, 1978). This serves as a guide for interventions into the system.

The role of the counsellor encompasses a variety of areas. At the onset of therapy, the counsellor joins with the family and becomes part of the system. While maintaining

some distance, he/she acts as a facilitator and as a guide to lead the family to a crisis resolution. When dealing with a family which is having difficulties adjusting to their new circumstances, he/she can encourage family members to openly discuss and express their feelings; anger, fear, joy or relief, concerning the life threatening illness. Open and honest communication can facilitate the adaptation process necessary for dealing effectively with the crisis. The counsellor can guide the family to working out new methods of behaviour and appropriate solutions to presenting problems.

Family patterns can be used to implement, permit the planning of and serve as a guide for the most appropriate strategy of therapeutic interventions. Therapy can focus in on areas to promote family stability, cohesion and flexibility at what is a difficult time for them. Interaction and communication patterns can be looked at and, if needed, altered to help members adapt to changes and weather the crisis.

Altering family rules can be another point for intervention. If rules are rigid, debilitating to accommodating and adapting to necessary changes, counselling can facilitate and help modify these rules and add flexibility to the system.

Similar interventions may be applied to families in other crisis situations. Although the crisis in the present study was the diagnosis of cancer, other life threatening

illnesses may present parallel problems for a family. Therefore, similar interventions can be applied to a variety of conditions.

Implications for Future Research

The value of phenomenological, experiential research and a self report study is the in depth findings one can explore. Questions are generally open ended allowing for more freedom in responding. As well, the researcher has the freedom of exploring responses in fuller detail.

Future research is indicated to confirm findings of the present study for different types of cancer and other life threatening illnesses. As well, confirmation is needed to relate findings to illness in family members other than the wife/mother.

Research is suggested to explore the efficacy of counselling interventions to promote flexibility and successful and functional adaptation for families facing a crisis situation.

Findings of this study, could be used to generate hypotheses meriting future empirical research. It could be hypothesized that changes resulting from a terminal illness would be more dramatic and more permanent than those found in the present study which dealt with nonterminal illness. As well, this study explored illness in a female/wife/

mother. Illness in a male/husband/father, or in a child would have different effects on family members.

Different forms of cancer require different treatments and follow different processes. For example, leukaemia may result in different changes in a patient and his/her family than breast cancer or stomach cancer. Some require constant therapy, some require surgery alone, and others require more than one form of treatment. It is proposed that an experimental study could be done to compare changes which occurred in members responding to the wide variety of cancer illnesses, terminal versus nonterminal cases, and investigate changes resulting from cancer in different family members.

Limitations

Various limitations are evident in the present research. As in any case study approach, results cannot be generalized across all populations. Results of this study are relevant for the two subject families. A second limitation is that not all members of the A. Family were present. Each member is important within the system and would have added essential information.

The two families were volunteer subjects. They may indicate different responses than others who are unwilling to participate in such a study. As well, although responses

were reflective of their perceptions, all material was retrospective. Ideas, thoughts and feelings can change over time. Results may be different if interviews took place immediately following the crisis period. One cannot be sure their answers were accurate. They may have given responses they believe to be socially desirable. Defense mechanisms, for example, denial, may have inhibited subjects from responding to some questions in a certain way, particularly those of a more personal nature.

Lastly, both women who had cancer have recovered from the illness. Both cases were nonterminal. Families dealing with terminal cancer, or a cancer which reoccurs may go through a very different change process than those interviewed in this study. Cancer in a husband or child, as well, may reflect different results.

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Appendix A

Interview Schedule

1) Family Data and Background

age and sex of family members

education

occupaton

religion

years married

previous illness related experience

2) Medical Data and Background

diagnosis

date of diagnosis

treatment

prognosis

3) Changes since diagnosis in fulfilling various functions within the family

a) Has there been any changes within the family in terms of financial support? Who worked before the cancer, during, and after? Has there been a change in your standard of living?

b) Has there been a change in the area of child rearing, for

example, driving the children around, helping them with their homework, other?

c) Has there been any changes in who does the household duties, for example, cooking, cleaning; dusting and vacuuming, laundry, grocery shopping, household maintenance, other?

d) Has there been a change in the area of affection, for example, touching, sexual relations, gift giving, laughing, other? Has this occurred more or less frequently?

e) Were any changes evident in the domain of emotional support and security, for example, who was the confidence builder, who gave the helping hand, had the shoulder to lean on? Was this different before, during, after the diagnosis?

f) Were there changes in the area of decision making, regarding, for example, spending finances, holidays, other?

g) Has a change occurred in observing one's religious beliefs?

h) Has there been a change in social relatonships, for example, do you go out more or less, is there a difference in how people approach you?

i) Has there been a change in one's feelings of fear and vulnerability?

j) Has there been a change in priorities, outlook in life, do you approach life differently now from before?

4) Who has facilitated these changes?

family members

extended family

friends

minister

counsellor

support group

Appendix B

Follow-Up Interview

1) "_____, how do you see the relationship between _____ and _____?"

2)"_____, which two people in the family do the most arguing?"

3) "_____, which two people in the family argue the least?"

4) "_____, who in the family does most of the reprimanding?"

Appendix C

Consent Form

We agree to participate in a study as described and conducted by Terry Kaplovitch on family changes as a result of cancer and, to be interviewed to provide information describing what changes we have gone through resulting from a diagnosis of cancer in a family member. In exchange, we understand that we will receive feedback about the results after completion of the study.

Furthermore, we understand that the interview will be recorded on audiotape and that the tape will be erased after the study is completed. We understand that we will not be identified by name and only those directly involved in the study will have access to confidential information.

_____

_____

_____